

CERTIFICATE OF DEATH

Reg. Dist. No.

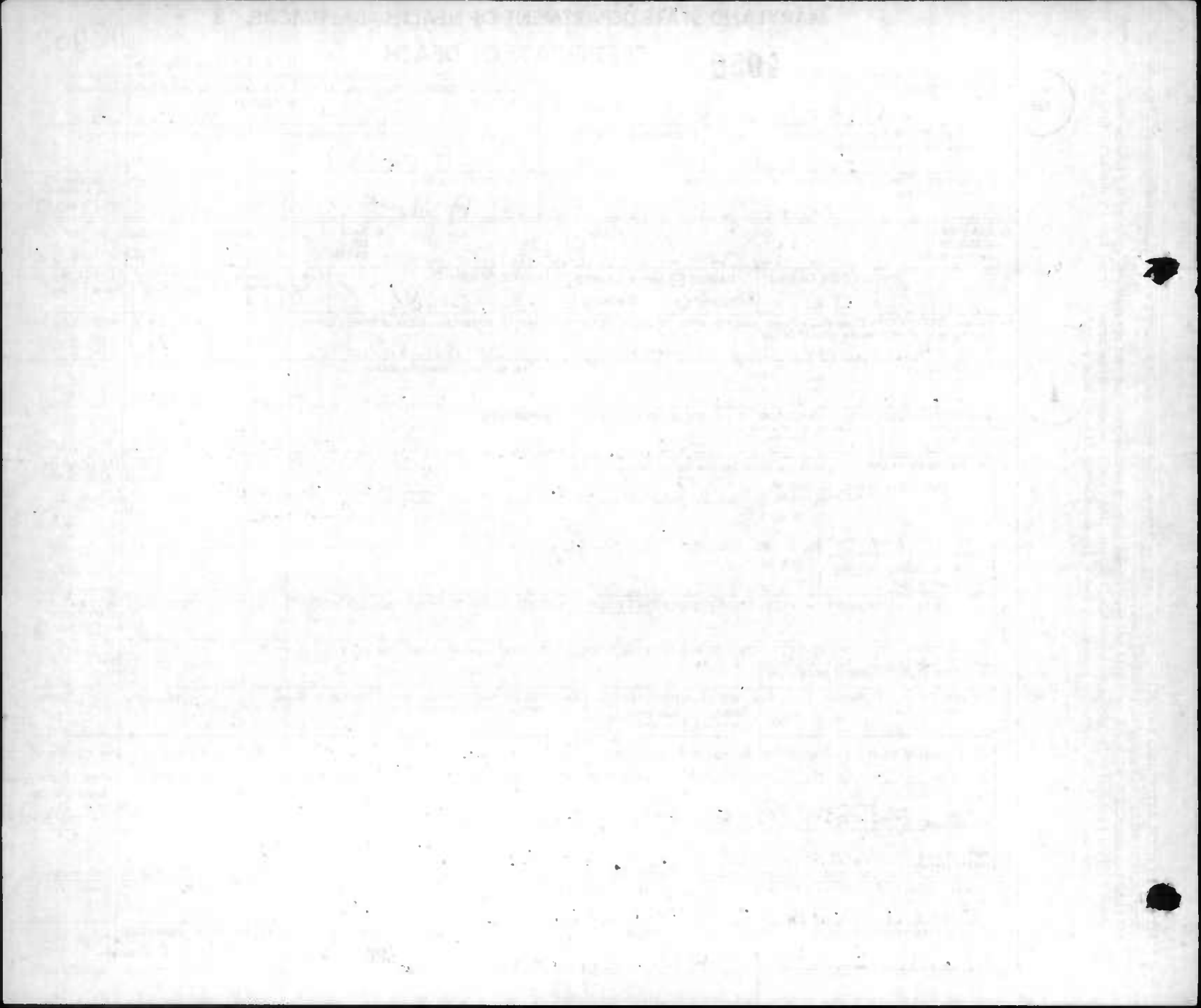
03982

4050

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route # 3</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>Bridgell</u> Last <u></u>				4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>AA</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-15-1861</u>	
9. AGE (In years last birthday) <u>98</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Henry Bethards</u>				14. MOTHER'S MAIDEN NAME <u>Hester Hammond</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u>No</u>			
17. INFORMANT Address <u>Joseph C. Bridgell - Rt #3 - Berlin, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Senility</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>about year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12-23</u> , 19 <u>53</u> , to <u>3/12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/12</u> , 19 <u>60</u> , and that death occurred at <u>5 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ivory U. Sully, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Berlin, Md.</u> DATE SIGNED <u>3/24/60</u>			
PHYSICIAN'S NAME (Type) <u>Ivory U. Sully, Jr., MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-26-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Bethel Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Therence B. Sully, Salisbury, Md.</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR DATE <u>APR 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4051

CERTIFICATE OF DEATH

03983

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN NORTH</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Berlin, Md (RFD #2)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MABLE W. CATHELL</u>		4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/27/08</u>
9. AGE (In years last birthday) <u>51 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>EDGAR EVANS</u>	
14. MOTHER'S MAIDEN NAME <u>MATTIE HUDSON</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>HARRY CATHELL Berlin MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute bronchial asthmatic attack</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Bronchial asthma</u> DUE TO (c) <u>2 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-14</u> , 19 <u>58</u> , to <u>3-8</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3-8</u> , 19 <u>60</u> , and that death occurred at <u>6:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ivory V. Sully, Jr. MD.</u>		ADDRESS (Street, city or town, state) <u>Berlin Md</u> DATE SIGNED <u>3/16/60</u>	
PHYSICIAN'S NAME (Type) <u>Ivory V. Sully, Jr. MD</u>		<u>Berlin, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/20/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST GEORGES Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>CHARLSVILLE DELAWARE</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Watson & Gray</u> ADDRESS <u>Frankford, Del.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 22 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

MEDICAL CERTIFICATION

1

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 19

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4043 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03984

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> c. LENGTH OF STAY IN 1b <u>66 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BERLIN</u> d. STREET ADDRESS <u>1 WILLIAMS ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>VAUGHN EVERETT CROPPER</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>5</u> Year <u>1900</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 15, 1894</u>		9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MERCHANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN STORE</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD (QFD)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH CROPPER</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH TURNER</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NO</u>		17. INFORMANT Address <u>MRS. V. EVERETT CROPPER BERLIN MD</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute Coronary Thrombosis with</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Pulmonary Edema</u> DUE TO (c) <u>Coronary Artery Disease</u>								INTERVAL BETWEEN ONSET AND DEATH <u>10 Min</u> <u>Minutes</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Herman A. Robbins</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) <u>Herman A Robbins M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/8/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna H. Burbage</u>				ADDRESS <u>Berlin md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton E. Howard</u>	

MEDICAL CERTIFICATION

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03985

4048

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Morristown</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Morristown</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>				c. LENGTH OF STAY IN 1b <u>3760-23 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rebecca</u> Middle <u>mae</u> Last <u>Jackson</u>				4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 12 - 1909</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>23</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Snow Hill MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u></u>							
13. FATHER'S NAME <u>Ernest Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Helen Beckett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>Mrs Helen Jackson Snow Hill MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>MARCH 4, 1960</u> to <u>MARCH 5, 1960</u> , that I last saw the deceased alive on <u>MARCH 5, 1960</u> , and that death occurred at <u>4 A. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert C. LaMar</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Robert C. LaMar, M. D.</u>				<u>Snow Hill, Maryland</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial March 6/60</u>				22b. NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>		22c. LOCATION (City, town, or county) (State) <u>Snow Hill MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Harris</u>				ADDRESS <u>Snow Hill MD</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 8 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>William L. Harris</u>	

40VV246XV5

1000

CERTIFICATE OF DEATH

1918

1000
1000

[Faint, mostly illegible text, likely a death certificate form with fields for name, date, and location.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03986

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Jones</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>5</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 8, 1917</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Work</u>	
11. BIRTHPLACE (State or foreign country) <u>Beaufort Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>Martha JONES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Perlie Jones</u>		Address <u>Pocomoke City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Heart</u> <u>982x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to stab wound</u> DUE TO (c) <u>Homicide</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Drinking Alcohol drinks</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Stabbed by another person following a party</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>3</u> p. m. <u>May 4</u> 19 <u>60</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Pocomoke City, Worcester, Md.</u> (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>N.E. Sartorius M.D.</u>		DATE SIGNED <u>3/4/60</u>	
EXAMINER'S NAME (Type) <u>N.E. Sartorius</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/18/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Beaufort</u>	22d. LOCATION (City, town, or county) (State) <u>Beaufort, N.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Eldgo - Wharton - Newchurch</u>		24a. REC'D BY REGISTRAR <u>MAR 18 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>

MEDICAL CERTIFICATION

2

TO THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH - ALBANY
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES J. JONES		45		M		W		JAN 15 1910	
RESIDENCE		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER	
123 Main St., Albany, N.Y.		Home		Heart Disease		Natural		J. H. Smith, M.D.	
OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		SIGNED	
Clerk		High School		Roman Catholic		Married		J. H. Smith, M.D.	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ACCIDENTS	
None		None		None		None		None	
HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS	
Patient was well until about one week before death, when he began to feel ill. He had no fever, no cough, no pain, and no other symptoms. He continued to work until the day before death, when he was found dead in his bed.		Patient was well until about one week before death, when he began to feel ill. He had no fever, no cough, no pain, and no other symptoms. He continued to work until the day before death, when he was found dead in his bed.		Patient was well until about one week before death, when he began to feel ill. He had no fever, no cough, no pain, and no other symptoms. He continued to work until the day before death, when he was found dead in his bed.		Patient was well until about one week before death, when he began to feel ill. He had no fever, no cough, no pain, and no other symptoms. He continued to work until the day before death, when he was found dead in his bed.		Patient was well until about one week before death, when he began to feel ill. He had no fever, no cough, no pain, and no other symptoms. He continued to work until the day before death, when he was found dead in his bed.	
POST-MORTEM EXAMINATION		POST-MORTEM EXAMINATION		POST-MORTEM EXAMINATION		POST-MORTEM EXAMINATION		POST-MORTEM EXAMINATION	
None		None		None		None		None	
FINDINGS		FINDINGS		FINDINGS		FINDINGS		FINDINGS	
The body was well developed, well nourished, and well kept. The skin was fair, and the hair was dark. The eyes were closed, and the mouth was slightly open. The throat was clear, and the lungs were clear. The heart was enlarged, and the kidneys were normal. The stomach was normal, and the intestines were normal. The bladder was normal, and the prostate was normal. The testicles were normal, and the penis was normal. The spine was normal, and the ribs were normal. The skull was normal, and the brain was normal. The lungs were normal, and the heart was normal. The kidneys were normal, and the stomach was normal. The intestines were normal, and the bladder was normal. The testicles were normal, and the penis was normal. The spine was normal, and the ribs were normal. The skull was normal, and the brain was normal.		The body was well developed, well nourished, and well kept. The skin was fair, and the hair was dark. The eyes were closed, and the mouth was slightly open. The throat was clear, and the lungs were clear. The heart was enlarged, and the kidneys were normal. The stomach was normal, and the intestines were normal. The bladder was normal, and the prostate was normal. The testicles were normal, and the penis was normal. The spine was normal, and the ribs were normal. The skull was normal, and the brain was normal. The lungs were normal, and the heart was normal. The kidneys were normal, and the stomach was normal. The intestines were normal, and the bladder was normal. The testicles were normal, and the penis was normal. The spine was normal, and the ribs were normal. The skull was normal, and the brain was normal.		The body was well developed, well nourished, and well kept. The skin was fair, and the hair was dark. The eyes were closed, and the mouth was slightly open. The throat was clear, and the lungs were clear. The heart was enlarged, and the kidneys were normal. The stomach was normal, and the intestines were normal. The bladder was normal, and the prostate was normal. The testicles were normal, and the penis was normal. The spine was normal, and the ribs were normal. The skull was normal, and the brain was normal. The lungs were normal, and the heart was normal. The kidneys were normal, and the stomach was normal. The intestines were normal, and the bladder was normal. The testicles were normal, and the penis was normal. The spine was normal, and the ribs were normal. The skull was normal, and the brain was normal.		The body was well developed, well nourished, and well kept. The skin was fair, and the hair was dark. The eyes were closed, and the mouth was slightly open. The throat was clear, and the lungs were clear. The heart was enlarged, and the kidneys were normal. The stomach was normal, and the intestines were normal. The bladder was normal, and the prostate was normal. The testicles were normal, and the penis was normal. The spine was normal, and the ribs were normal. The skull was normal, and the brain was normal. The lungs were normal, and the heart was normal. The kidneys were normal, and the stomach was normal. The intestines were normal, and the bladder was normal. The testicles were normal, and the penis was normal. The spine was normal, and the ribs were normal. The skull was normal, and the brain was normal.		The body was well developed, well nourished, and well kept. The skin was fair, and the hair was dark. The eyes were closed, and the mouth was slightly open. The throat was clear, and the lungs were clear. The heart was enlarged, and the kidneys were normal. The stomach was normal, and the intestines were normal. The bladder was normal, and the prostate was normal. The testicles were normal, and the penis was normal. The spine was normal, and the ribs were normal. The skull was normal, and the brain was normal. The lungs were normal, and the heart was normal. The kidneys were normal, and the stomach was normal. The intestines were normal, and the bladder was normal. The testicles were normal, and the penis was normal. The spine was normal, and the ribs were normal. The skull was normal, and the brain was normal.	
TESTIMONY		TESTIMONY		TESTIMONY		TESTIMONY		TESTIMONY	
None		None		None		None		None	
SIGNATURE OF EXAMINER		SIGNATURE OF EXAMINER		SIGNATURE OF EXAMINER		SIGNATURE OF EXAMINER		SIGNATURE OF EXAMINER	
J. H. Smith, M.D.		J. H. Smith, M.D.		J. H. Smith, M.D.		J. H. Smith, M.D.		J. H. Smith, M.D.	
DATE		DATE		DATE		DATE		DATE	
JAN 15 1910		JAN 15 1910		JAN 15 1910		JAN 15 1910		JAN 15 1910	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03987

4044

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. LENGTH OF STAY IN 1b <u>75 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BERLIN</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1 R.F.D.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GARLIE</u> Middle <u>H.</u> Last <u>McCABE</u>				4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 14, 1884</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u> Hours <u>19</u> Min.	IF UNDER 24 HRS. Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD (RFD)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSHUA McCABE</u>				14. MOTHER'S MAIDEN NAME <u>MARGARETT TIMMONS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Mr LINWOOD McCABE</u> Address <u>BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO <u>Coronary Sclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>1 yr</u> <u>3-4 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Herman A. Robbins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Herman A Robbins M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u>				ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 15 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Charles E. House</u>	

MEDICAL CERTIFICATION

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute this certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

4052

4052

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03988

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Margaret</i> Middle <i>D.</i> Last <i>Melton</i>		4. DATE OF DEATH Month <i>March</i> Day <i>13</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 10 - 1869</i>
9. AGE (In years last birthday) <i>91</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Snow Hill, md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Friedrich Haubert</i>		14. MOTHER'S MAIDEN NAME <i>Mary Briddell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs. Bryon Dill</i> Address <i>Snow Hill, md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema</i> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial Insufficiency</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>12 Hrs</i> <i>1 yr</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Lobar Pneumonia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1948</i> 19... to <i>3-13-60</i> , that (I) was last saw the deceased alive on <i>3-13-60</i> , and that death occurred at <i>10A</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert C. LaMar</i>		22b. DATE SIGNED <i>March 15, 1960</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert C. LaMar, M. D.</i>		22d. ADDRESS <i>104 Bay Street, Snow Hill, Md</i>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <i>Burial March 16/60</i>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <i>St. Peter's Methodist</i>		23d. LOCATION (City, town, or county) (State) <i>Snow Hill, md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Walter E. Ginn</i>		25. REC'D BY REGISTRAR <i>Charles S. House</i>	
25a. ADDRESS <i>Snow Hill, md</i>		25b. REGISTRAR'S SIGNATURE	
25c. DATE <i>MAR 16 '60</i>			

[Faint, illegible text, likely bleed-through from the reverse side of the page. Some words are difficult to discern but appear to include:]

My mother, Mary Ann [illegible]
born [illegible]
1942
1-12-20

CERTIFICATE OF DEATH

Reg. Dist. No.

03989

4047

1. PLACE OF DEATH a. COUNTY Worcester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN 1b 10 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Worcester		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 Pocomoke City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 Greenway Avenue						d. STREET ADDRESS 1509 Linden Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BERTIE		Middle H.		Last MERRILL		4. DATE OF DEATH Month March		Day 21		Year 1960	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 22, 1891		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Edward Thomas Hope						14. MOTHER'S MAIDEN NAME Sudie B. Bundick					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) ---		17. INFORMANT W. H. Merrill Jr., Pocomoke City, Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized atherosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Few minutes years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arthritis, Chronic.											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Pocomoke City, Md.		(County) (State)	
21. I certify that I attended the deceased from Oct. 4, 1959 , to Mar. 21, 1960 , that I last saw the deceased alive on Mar. 21, 1960 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 302 Market St. Pocomoke City, Md. 3-22-60											
ACTUAL SIGNATURE Charles W. Trader				M.D. Charles W. Trader, M.D.							
PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-24-60		22c. NAME OF CEMETERY Bethany Methodist				22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Robert H. Watson				ADDRESS Pocomoke City, Md.				24a. REC'D BY REGISTRAR MAR 28 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

401

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1900		Boston, Mass.	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Roman Catholic	
Date of Death		Place of Death		Physician		Hospital		Burial Place	
Jan 15, 1945		Home		Dr. J. Smith		St. Mary's		St. Mary's Cemetery	
Signature of Physician		Signature of Registrar		Signature of Deceased		Signature of Family		Signature of Minister	
J. Smith		A. Doe		John Doe		Mary Doe		Father	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1. **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03990

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
c. LENGTH OF STAY IN 1b <u>4 hrs</u>		d. STREET ADDRESS <u>204 Belt Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>204 Belt Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>L</u> Last <u>Mills</u>		4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 21-1911</u>
9. AGE (In years last birthday) <u>48 1/2</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Mill</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Ernest S. Mills</u>		14. MOTHER'S MAIDEN NAME <u>Annice Lewis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>216-09-4271</u>	
17. INFORMANT <u>msm Margaret S. Mills, Snow Hill, md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO <u>241X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Insufficiency</u> DUE TO (c) <u>Chronic Bronchitis Asthma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 wks.</u> <u>1 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Bronchitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> 19 <u>56</u> to <u>3-14-60</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>3-12-60</u> , and that death occurred at <u>2:00</u> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert C. LaMar</u>		22b. DATE SIGNED <u>March 15, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert C. LaMar, M. D.</u>		22d. ADDRESS <u>104 Bay Street, Snow Hill, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 17/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Whitcomb Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Snow Hill, md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Gibbs</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 16 '60</u>	
ADDRESS <u>Snow Hill, md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

1043

1

[Faint, mostly illegible handwritten text, likely a death certificate form with fields for name, date, and cause of death.]

[Handwritten signature or initials.]

[Faint, mostly illegible handwritten text at the bottom of the page, possibly a continuation of the form or additional notes.]

4053

CERTIFICATE OF DEATH

Reg. Dist. No.

03991

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEWARK</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>NEWARK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Edward Pointer</u> First Middle Last				4. DATE OF DEATH <u>MAR. 6</u> 19 <u>60</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 17, 1879</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE E. POINTER</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET QUILLEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-12-3297</u>		INFORMANT <u>Mrs. G.E. Pointer</u>		Address <u>NEWARK MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> <u>593X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chr. Brights</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Feb 24 - 1960</u> , to <u>March 6, 1960</u> , that I lost the deceased alive on <u>March 5 - 1960</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas. R. Law</u>				ADDRESS (Street, city or town, state) <u>Berlin Md</u>		DATE SIGNED <u>March 8 - 1960</u>	
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/7/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) <u>BERLIN MD</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Amos A. Burbage</u>				ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR <u>MAR 10 '60</u> DATE	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

CERTIFICATE OF ORIGIN

1923

Export of Merchandise
To: *United States*
From: *United States*

Value of Merchandise
\$100.00

Signature of Exporter
[Signature]

Signature of Importer
[Signature]

Signature of Customs Officer
[Signature]

Signature of Agent
[Signature]

Signature of Broker
[Signature]

Signature of Collector
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4054

CERTIFICATE OF DEATH

Reg. Dist. No.

03992

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Newark		c. LENGTH OF STAY IN 1b life time	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Selby		4. DATE OF DEATH 3 24 19 60	
5. SEX M	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-14-1865
9. AGE (In years lost birthday) 94 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Selby		14. MOTHER'S MAIDEN NAME Talbothy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Margie Johnson, Rt #1, Newark, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 431X acute myocarditis Conditions, if any, which gave rise to immediate cause (c), stating the under: lying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 3-24 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-24 19 60 to 3-24 19 60, that I last saw the deceased alive on 3-24-60, 19 60, and that death occurred at 9:00 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Clifford E. Schott M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 314 N. Main Berlin Md.	
PHYSICIAN'S NAME (Type) Clifford E. Schott. M.D.		314 N. Main Street, Berlin, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-30-60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Chapel Cem.		22d. LOCATION (City, town, or county) (State) NEWARK, N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE Thornton B. Jolley, Salisbury, Md		24a. REC'D BY REGISTRAR DATE APR 4 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

STATE OF NEW YORK
IN SENATE
JANUARY 10, 1913
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
MAY 1, 1912
ALBANY: J.B. LIPPINCOTT COMPANY, PRINTERS.
1913.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4045

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03993

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY NORFOLK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY NORFOLK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1 FRANKLIN AVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) CLINTON BOSTON TAYLOR				4. DATE OF DEATH MAR. 19 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 18, 1919		9. AGE (In years last birthday) 40 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY OWN STORE		11. BIRTHPLACE (State or foreign country) NEWARK MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN TAYLOR				14. MOTHER'S MAIDEN NAME MARY BOSTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 220-91-8690		17. INFORMANT MRS. C.B. TAYLOR, BERLIN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforating G.S.W. left side of chest DUE TO 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) through heart, DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Melancholy				INTERVAL BETWEEN ONSET AND DEATH 15 Min			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self Inflicted with 25 cal automatic pistol					
20c. TIME OF INJURY Month, Day, Year 11 Mar 19 1960		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> Home		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Berlin (County) Worcester (State) Co	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Herman A Robbins				DATE SIGNED March 21, 1960			
EXAMINER'S NAME (Type) Herman A Robbins M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/22/60		22c. NAME OF CEMETERY OR CREMATORY EVERGREEN		22d. LOCATION (City, town, or county) BERLIN MD	
23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage				24a. REC'D BY REGISTRAR MAR 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

MEDICAL CERTIFICATION

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPUTY